

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATE NAME Fountain, Jerry AIS# 152157Medication Allergies: MOTILINMedical: Chronic (Long-Term) Problems
Roman Numerals for Medical/SurgicalMental Health Code: SMI HARM HIST NONE
Capital Letter for Psychiatric Behavior

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provider Initials

**If Asthmatic label: Mild – Moderate – or Severe.

PROBLEM LIST

Name _____

ID #

D.O.B.

Medication Allergies

[illegible]



RELEASE OF RESPONSIBILITY

Inmate's Name: Tony Fountain

Date of Birth: 8-24-62

Social Security No.: 423-92-6962

Date: 10-5-04

Time: 12:20 P.M.

A.M.
P.M.

This is to certify that I, Tony Fountain

(Print Inmate's Name)

, currently in

custody at the Staten Correction Facility

(Print Facility's Name)

, am refusing to

accept the following treatment/recommendations:

Chronic Chest Pain

(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Tony Fountain
(Signature of Inmate)**

[Signature]
(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



RELEASE OF RESPONSIBILITY

Inmate's Name: Fountain, Tony 152157Date of Birth: 8/24/62 Social Security No.: _____Date: 9/23/04 Time: _____ A.M.
P.M.This is to certify that I, TONY FOUNTAIN, currently in
(Print Inmate's Name)
custody at the STATION, am refusing to
(Print Facility's Name)

accept the following treatment/recommendations:

No Show For Sick Call
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

(Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



RELEASE OF RESPONSIBILITY

Inmate's Name:

Fountain, Tony

Date of Birth:

8/24/62

Social Security No:

Date:

6/15/04

Time:

2P

A.M.
P.M.

This is to certify that I,

Fountain, Tony

(Print Inmate's Name)

, currently in

custody at the

Stuton

(Print Facility's Name)

, am refusing to

accept the following treatment/recommendations:

Clinic

No Show for M.D.

(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

(Signature of Inmate)**

McLain

(Witness)

(Signature of Medical Person)

BL

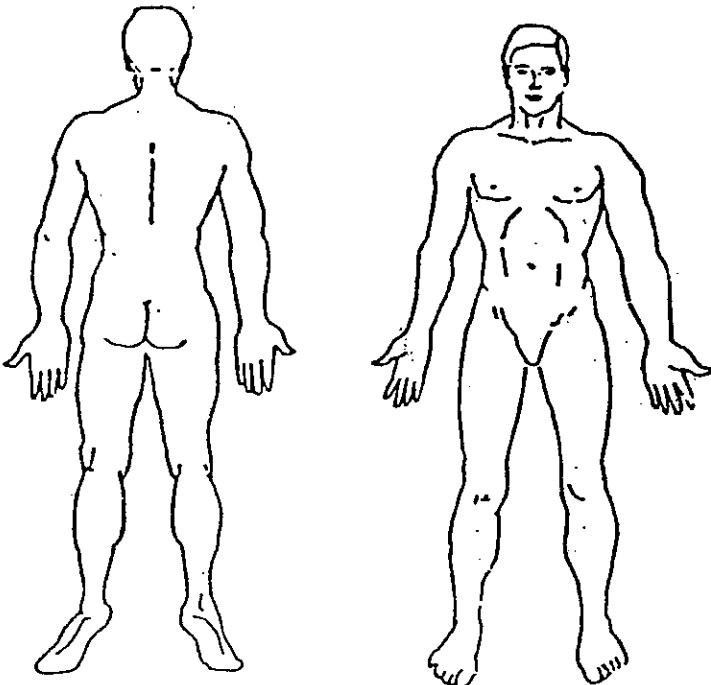
(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

DEPARTMENT OF CORRECTIONS

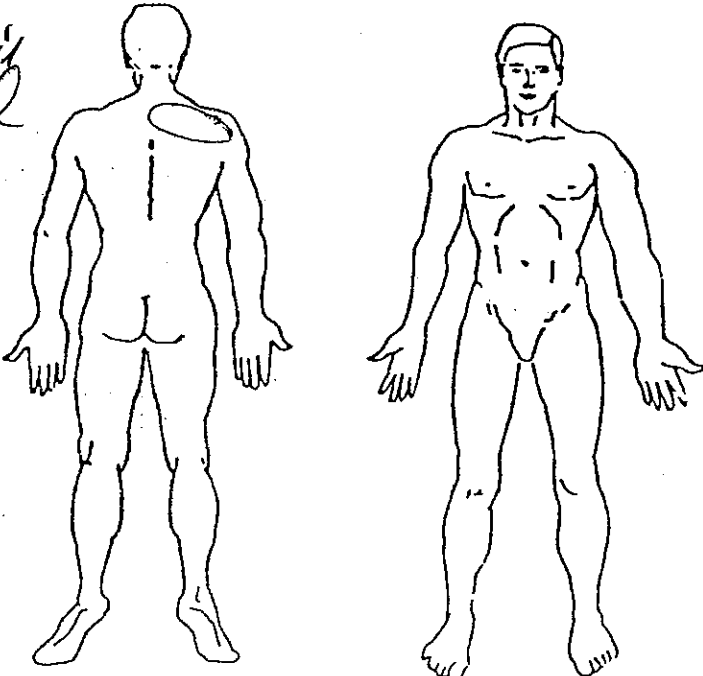
EMERGENCY/ SHCU TREATMENT RECORD

(OTHER)

DATE <u>2-5-02</u>		TIME <u>10¹⁰</u> <u>AM</u> PM	FACILITY <u>SEC</u>		<input type="checkbox"/> EMERGENCY <input type="checkbox"/> OTHER	
ALLERGIES <u>Motrin - Rash</u>			CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP <u>97³</u> <u>ORAL</u> RECTAL			RESP. <u>20</u>	PULSE <u>88</u>	B/P <u>140</u> <u>190</u>	RECHECK IF SYSTOLIC <u> </u> <100> 50
NATURE OF INJURY OR ILLNESS <u>S: In a fight</u> <u>Denies cuts, lacerations</u> <u>Bruised</u> <u>D: Brought in by officer</u> <u>for Body Chart</u>			ABRASION//	CONTUSION #	BURN <u>XX</u> <u>XX</u>	FRACTURE <u>Z</u> LACERATION/ SUTURES
						
PHYSICAL EXAMINATION <u>A: Body Chart per Doc</u> <u>P: Released to Doc</u>						
ORDERS, MEDICATION, etc.						
DIAGNOSIS						
INSTRUCTIONS TO PATIENT						
RELEASE/TRANSFER DATE <u>2 / 5 / 02</u>		TIME <u>10</u> <u>AM</u> PM	RELEASE/TRANSFERRED TO <u>DOC</u>		<input type="checkbox"/> AMBULANCE <input type="checkbox"/>	
NURSE'S SIGNATURE <u>B Helms CRNP</u>		DATE <u>2-5-02</u>	PHYSICIAN'S SIGNATURE <u>B Helms CRNP</u>		DATE <u>2-5-02</u>	CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL
PATIENT'S NAME (LAST, FIRST, MIDDLE) <u>Fountain, Tony</u>		AGE <u>39</u>	DATE OF BIRTH <u>8/24/62</u>		R/S <u>B/m</u>	AIS # <u>152157</u>

DEPARTMENT OF CORRECTIONS

EMERGENCY/ (OTHER) TREATMENT RECORD

DATE <u>8.25.01</u> TIME <u>530</u> <u>AM</u> <u>PM</u>		FACILITY <u>Sec</u>		<input type="checkbox"/> EMERGENCY <input type="checkbox"/> OTHER	
ALLERGIES <u>None</u>		CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP <u>99.2</u> <u>ORAL</u> RECTAL <u>20</u> PULSE <u>68</u> B/P <u>110/70</u>		RECHECK IF SYSTOLIC <u><100> 50</u>			
NATURE OF INJURY OR ILLNESS <u>S- Something was crawling on my neck and feet it pitted when I killed it. Didn't see what it was - just assumed it was a spider</u>		ABRASION///		CONUSION #	BURN <u>XX</u> <u>XX</u>
				FRACTURE <u>Z</u>	LACERATION/ SUTURES
PHYSICAL EXAMINATION <u>O - Cerviculated to Hcy & small red wheal noted to scapula area & broken skin only redness around wheal SOB & acute distress @ present</u> <u>A - Attention in comfort</u>					
ORDERS, MEDICATION, etc. <u>P - Continued MD to review</u> <u>2) return to pull call if SOB occurs</u>					
DIAGNOSIS					
INSTRUCTIONS TO PATIENT <u>V Pull call Monday night</u>					
RELEASE/TRANSFER DATE <u>8.25.01</u> TIME <u>540</u> <u>AM</u> <u>PM</u>		RELEASE/TRANSFERRED TO <input type="checkbox"/> DOC <input checked="" type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE <u>Smilican</u>		DATE <u>8.25.01</u>		PHYSICIAN'S SIGNATURE <u>MD J. M. W.</u>	
PATIENT'S NAME (LAST, FIRST, MIDDLE) <u>Fountain Sony</u>		AGE <u>8</u>		DATE OF BIRTH <u>8/26/63</u>	
		R/S		AIS # <u>152157</u>	

DEPARTMENT OF CORRECTIONS

TREATMENT REQUEST AND RECORD

TREATMENT REQUEST AND RECORD			
Date of Request 2/20/01	Requested by Dr. Taylor	Patient Status <input type="checkbox"/> IP <input type="checkbox"/> OP	Rs. Ordered
Clinical Diagnosis Irrigate both ears			Order of Order
			Date of Surgery

AREA OF TREATMENT (CIRCLE)

PROGRESS NOTES. *Began destroy*
2-20-01 both ears cmc
2-23-01 show (popped) cm
2-MARCH 2001 irrigated

RECORD OF TREATMENT

[illegible]

Fountian, Tony
Name of Inmate

8/16/98 11:40
Date/Time

152151 8/24/63
Inmate ID Number / Date of Birth

I hereby refuse to accept the following treatment/recommendations:

I dont want to take my blood

I acknowledge I have been fully informed of and understand the above treatments or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless Correctional Medical Systems, its employees and agents from all responsibility and ill effect which may result from this action.

[Signature]
Inmate Signature

8/16/98
Date/Time

[Signature]
Witness

The aforementioned inmate has refused the listed medical treatment/recommendations and has refused to sign this form.

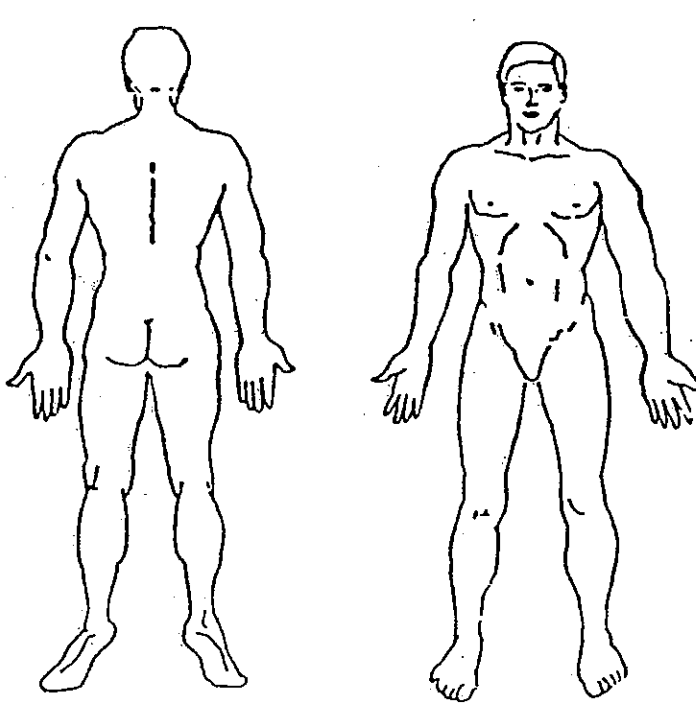
Witness

Witness

Date/Time

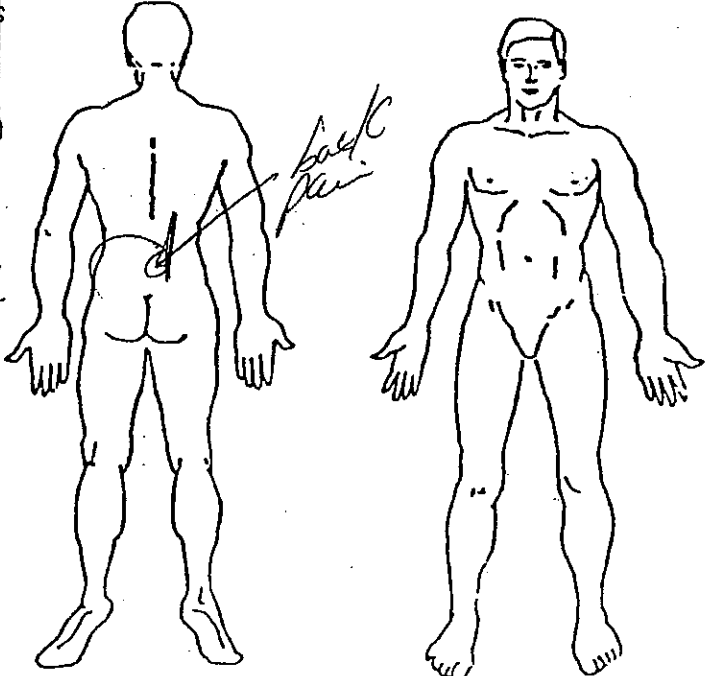
[Signature]

152/5

DATE <u>2/24/99</u> TIME <u>20:15</u> <u>PM</u>		FACILITY <u>BOCF</u>		<input type="checkbox"/> EMERGENCY	
		<input type="checkbox"/> SIR <input type="checkbox"/> PDL <input type="checkbox"/> ESCAPEE <input type="checkbox"/>		<input type="checkbox"/> OTHER	
ALLERGIES <u>nutrien</u>		CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP <u>98.5</u> <u>ORAL</u> <u>RECTAL</u> RESP. <u>24</u>		PULSE <u>119</u> B/P <u>140/87</u>		RECHECK IF SYSTOLIC <100> 50	
NATURE OF INJURY OR ILLNESS <u>(S) "my head aches I got the fever and chills don't feel good"</u> <u>(D) imonate Apr 0 x3 no caught no distress noted all with WMR respirations even but labored.</u>		ABRASION/// CONTUSION # BURN ^{xx} / _{xx} FRACTURE ^Z / _Z LACERATION/ SUTURES			
PHYSICAL EXAMINATION <u>(A) attention in comfort</u> <u>(P) state cold medicine return if any symptoms get worse increase fluid</u>					
ORDERS, MEDICATION, etc. <u>Amoxicillin 500mg x 100 7 days</u> <u>Tylenol 650mg x 100 7 days</u> <u>NO. in bed dig</u>					
DIAGNOSIS					
INSTRUCTIONS TO PATIENT <u> fluids Take medication as directed</u>					
RELEASE/TRANSFER DATE <u>2/24/99</u> <u>PM</u>		TIME <u>PM</u>		RELEASE/TRANSFERRED TO <u>DOC</u> <input type="checkbox"/> AMBULANCE <input type="checkbox"/>	
NURSE'S SIGNATURE <u>M. Kealy RNC</u>		DATE <u>2/24/99</u>		PHYSICIAN'S SIGNATURE <u>[Signature]</u>	
PATIENT'S NAME (LAST, FIRST, MIDDLE) <u>Fountain, Tami</u>		AGE <u>36</u>		DATE OF BIRTH <u>8/26/53</u>	
		R/S <u>15/2</u>		AIS # <u>152/57</u>	

DEPARTMENT OF CORRECTIONS

EMERGENCY/ (OTHER) TREATMENT RECORD

DATE 4-25-98		TIME 10 ³⁰ AM		FACILITY BCCF		<input type="checkbox"/> EMERGENCY <input type="checkbox"/> OTHER	
ALLERGIES Molain				CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP 98.4		ORAL RECTAL		RESP. 20		PULSE 84 B/P 130/186	
NATURE OF INJURY OR ILLNESS				RECHECK IF SYSTOLIC <100 > 50			
				ABRASION//		CONTUSION #	
				BURN XX		FRACTURE Z	
				LACERATION/ SUTURES			
<p>3- I got a hx of back problems & my back went out on me. I'm taking naprosyn & it's hurting my stomach & not stopping the pain. I'm working in the kitchen & I just can't do the work bc my back problems.</p> <p>PHYSICAL EXAMINATION</p> <p>O- Present to the infirmary alert & oriented x3, Ambulatory slowly & slight forward tilt. C/o constant low back pain. Has current med order of 400 naprosyn of which he complains causes stable pain & is unrelievable. ROM compromised.</p> <p>A- Alternating ice/caps for back pain.</p> <p>ORDERS, MEDICATION, etc.</p> <p>P- No lifting, no prolonged standing & no bending until seen by MD on Monday.</p>							
DIAGNOSIS							
INSTRUCTIONS TO PATIENT							
Admit to infirmary 4/27/98							
RELEASE/TRANSFER DATE 4/25/98		TIME AM PM		RELEASE/TRANSFERRED TO <input type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE A. Brown		DATE		PHYSICIAN'S SIGNATURE		DATE	
PATIENT'S NAME (LAST, FIRST, MIDDLE) Fountain Tony				AGE 34		DATE OF BIRTH 8/24/63	
				R/S B/m		AIS # 152157	

CORRECTIONAL MEDICAL SYSTEMS
RELEASE OF INFORMATION

Jountain, Tony
Name of Inmate

Date/Time

152157
Inmate ID Number / Date of Birth

I hereby refuse to accept the following treatment/recommendations:

Sick Call

Inmate Refused to sign

I acknowledge I have been fully informed of and understand the above treatments or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless Correctional Medical Systems, its employees and agents from all responsibility and ill effect which may result from this action.

Inmate Signature

Date/Time

Matthe Jackson
Witness

The aforementioned inmate has refused the listed medical treatment/recommendations and has refused to sign this form.

Witness

Witness

Date/Time

N610

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

Inmate's Name: FOUNTAIN TDN Date: 3/3/98 Time: 109P
 DOB: 2/22/63 Officer: B. Brown Institution: BCCF

Booking Officer's Visual Opinion

- | | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| 1. Is the inmate conscious? | <u>✓</u> | <u> </u> |
| 2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services? | <u> </u> | <u> </u> |
| 3. Are there any visible signs of trauma or illness requiring immediate emergency treatment or doctor's care? | <u> </u> | <u> </u> |
| 4. Any obvious fever, swollen lymph nodes, jaundice, or other evidence of infection which might spread through the institution? | <u> </u> | <u> </u> |
| 5. Is the skin in poor condition or show signs of vermin or rashes? | <u> </u> | <u> </u> |
| 6. Does the inmate appear to be under the influence of alcohol or drugs? | <u> </u> | <u> </u> |
| 7. Are there any visible signs of alcohol or drug withdrawal? (extreme perspiration, shakes, nausea, pinpoint pupils, etc.) | <u> </u> | <u> </u> |
| 8. Is the inmate making any verbal threats to staff or other inmates? | <u> </u> | <u> </u> |
| 9. Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available? | <u> </u> | <u> </u> |
| 10. Does the inmate have any obvious physical handicaps? | <u> </u> | <u> </u> |

If the answer is YES to any questions from 2-10 above, specify WHY in section below.

- | | | |
|---|-----------|-----------|
| 11. Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder? | <u> </u> | <u> </u> |
| 12. Are you on any special diet prescribed by a physician? (If YES, what type?) | <u> </u> | <u> </u> |
| 13. Do you have a history of venereal disease or abnormal discharge? | <u> </u> | <u> </u> |
| 14. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness? | <u> </u> | <u> </u> |
| 15. Have you ever attempted suicide? | <u> </u> | <u> </u> |
| (If YES, When? _____ How? _____) | | |
| 16. Do you want to do any harm to yourself now? | <u> </u> | <u> </u> |

~~NaphCare~~

SCC

17-88-51
17-88-51

Release of Information Authorization

Tony Fountain *pt*
 Name of Inmate

SS# 423-69-6292

152157 / 08-24-1962

Inmate ID Number/Date of Birth

Jackson Hospital
 Facility Releasing Information

Monty

21 Nov 2001

Date

I hereby give my consent to NAPHCARE, INC. and the above named facility to release the following information from my medical record to the facility/provider listed below:

☒ Records related to treatment of Back pain
 from 1995 to Present

☒ Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care.

☒ Admission Reports

☒ Discharge Reports

☒ Operative Summary Reports

☒ X-Ray Reports

☒ Special Studies Reports

☒ Laboratory Reports

☐ Immunization History

☐ Mental Health Reports

☐ Psychiatric Summary Report

☐ Drug Treatment History and Counseling

☐ Other Records

S1 / TON HEALTH CARE UNIT

P.O. BOX 56

ELMORE, AL 36025

Medical Records
 Fax

334-567-1521

334-567-1538

Facility Releasing Information

mg

This information has been disclosed to you from records whose confidentiality is protected by State law. State regulations prohibit you from making any further disclosure of this information without the prior written consent of the person to whom it pertains.

I understand this authorization shall remain in full force and effect for the period of 90 days from today's date unless withdrawn in writing by me.

I sign this willingly, and I release NAPHCARE, INC. and the facility from any liability which may result from such release of information.

Inmate Signature

2-21-95

04163766-DRM

Date

21st Nov 2001

Witness

Witness

J. Sanders

FAXED
 12/12/01

JAN 18 2002

11415

Release of Information Authorization

Release of Information Authorization

Tony Fountain
Name of Inmate

Jackson Hospital
Facility Releasing Information

Monty

SS# 423-69-6292

152157 / 08-24-1926
Inmate ID Number/Date of Birth

21 Nov 2001
Date

Fax # 293-8969

I hereby give my consent to NAPHCARE, INC. and the above named facility to release the following information from my medical record to the facility/provider listed below:

☒ Records related to treatment of Back pain
from 1995 to Present

☒ Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care.

☒ Admission Reports

☒ Discharge Reports

☒ Operative Summary Reports

☒ X-Ray Reports

☒ Special Studies Reports

☒ Laboratory Reports

☐ Immunization History

☐ Mental Health Reports

☐ Psychiatric Summary Report

☐ Drug Treatment History and Counseling

☐ Other Records _____

S1 / TON HEALTH CARE UNIT

P.O. BOX 56

ELMORE, AL 36025

Medical Records
Fax

334-567-1521

334-567-1538

Facility Releasing Information

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[Signature]
Inmate Signature

21st Nov 2001
Date

[Signature]
Witness

[Signature]
Witness

Release of Information Authorization

FAXED
12/12/01

FAXED
01/13/02



NDOS 1780-S

Release of Information Authorization

Tony Fountain
Name of Inmate

SS# 423-69-6292

Jackson Hospital
Facility Releasing Information

152157 / 08-24-1962
Inmate ID Number/Date of Birth

21 Nov 2001
Date

Fax# 293-8969

I hereby give my consent to NAPHCARE, INC. and the above named facility to release the following information from my medical record to the facility/provider listed below:

☒ Records related to treatment of Back pain
from 1995 to Present

☒ Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care.

☒ Admission Reports

☒ Discharge Reports

☒ Operative Summary Reports

☒ X-Ray Reports

☒ Special Studies Reports

☒ Laboratory Reports

☐ Immunization History

☐ Mental Health Reports

☐ Psychiatric Summary Report

☐ Drug Treatment History and Counseling

☐ Other Records

S17 TON HEALTH CARE UNIT

P.O. BOX 56

ELMORE, AL 36025

Medical Records
Fax

334-567-1571

334-567-1538

Facility Releasing Information

This information has been disclosed to you from records whose confidentiality is protected by State law. State regulations prohibit you from making any further disclosure of this information without the prior written consent of the person to whom it pertains.

I understand this authorization shall remain in full force and effect for the period of 90 days from today's date unless withdrawn in writing by me.

I sign this willingly, and I release NAPHCARE, INC. and the facility from any liability which may result from such release of information.

[Signature]
Inmate Signature

21st Nov 2001
Date

[Signature]
Witness

[Signature]
Witness

FAXED
12/12/01

FAXED 3/15/00

Release of Information Authorization

REQUEST FOR MEDICAL RECORDS -- AREAS "A" AND "B" TO BE COMPLETED BY REQUESTING PARTY

10

REQUESTED BY:	Shore, J.	REQUESTING DEPARTMENT:	Corr.
PHONE:	293-8909	FAX:	293-8969
DATE:	1-17-02	TIME:	3:30
JOB #:		BOX #:	

22

ACCOUNT NUMBER	MONTH & YEAR OF SERVICE		SERV. TYPE	PATIENT NAME/DATE OF BIRTH	STAT REG	FAX DEL BOTH
04163766	2-21-95		INPT. OUTPT. ER	TONG Fountain 8-21-02	R	✓
INFORMATION REQUESTED -- CIRCLE ALL THAT APPLY FACESHEET D/S SUM H&P OP PATH CONSULTS EKGs ECHO XRAY ANESTHESIA ENTIRE RECORD SPECIAL INSTRUCTIONS OR REQUEST:						
LOCATION: (for DRG use)						

DIVERSIFIED RECORDS MANAGEMENT

COMMENTS:

FAXED BY:

PHONE: 334-280-0015
FAX: 334-280-2117

NUMBER OF PAGES (EXCLUDING COVER SHEET).

DIVERSIFIED RECORDS MANAGEMENT CORP. - 575 EAST PATTON AVENUE -

PHONE-- 384-260-0015

WEN/JOHNSTON, AL 36111
FAK--334-280-2177

Jackson Hospital
1725 Pine St.

Montgomery, AL 36106-1142

Dear Requestor:

RE: FOUNTAIN, TONY

Your request for medical record information on FOUNTAIN, TONY has been received; however, we are not able to process the request for information for the following reason(s):

- () Please provide date of birth, social security number, account number, medical record number, other names, or any other information you may have to enable us to locate this patient or treatment date.

DOB: _____ SS#: _____ DATE(S) OF SERVICE: _____
OTHER NAME(S): _____ OTHER INFORMATION: _____

- () Patient does not have date of treatment requested.
- () We require valid authorization, signed by the patient and dated within 90 days of the request.
- () We require a valid authorization signed by the parent of a minor or the legal guardian, accompanied by copies of the guardianship appointment papers.
- () We need a copy of the death certificate, showing next of kin or affidavit designating next of kin, or letters of administration and an authorization, signed by the next of kin.
- () Please supply the complete address where you want us to send copies of your records.
- () A specific request is required before releasing sensitive material. Please contact the patient.
- () Patient has not been seen at this facility.
- () Results from visit(s) of 2-21-95 are not on file.

If further information is requested, please return this form as quickly as possible. If we may be of further assistance, please feel free to contact us at the address or phone number listed below.

Thank you.

Smart Corporation - ROI

Jackson Hospital

334-293-8909

ROT
2/25/02
1130

1725 Pine St.

Montgomery, AL 36106-1142

Dear Requestor:

RE: FOUNTAIN, TONY

Your request for medical record information on FOUNTAIN, TONY has been received; however, we are not able to process the request for information for the following reason(s):

- () Please provide date of birth, social security number, account number, medical record number, other names, or any other information you may have to enable us to locate this patient or treatment date.

DOB: _____ SS#: _____ DATE(S) OF SERVICE: _____
OTHER NAME(S): _____ OTHER INFORMATION: _____

- ☒ Patient does not have date of treatment requested.
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- () Please supply the complete address where you want us to send copies of your records.
- () A specific request is required before releasing sensitive material. Please contact the patient.
- () Patient has not been seen at this facility.
- () Results from visit(s) of _____ are not on file.

If further information is requested, please return this form as quickly as possible. If we may be of further assistance, please feel free to contact us at the address or phone number listed below.

Thank you.

Smart Corporation - ROI

Jackson Hospital

334-293-8909

BT
3-29-02
0930

CORRECTIONAL MEDICAL SYSTEM
MEDICAL PROGRESS NOTES
INFIRMARY ADMISSIONINMATE'S NAME Fountain Tony
DATE 4-27-98INMATES NO. 152157
TIME _____

SOA	PLANS
S: BRIEF HISTORY:	P:
C/O pain several times. Does not want to work apparently	VITALS: <u>I daily</u>
	DIET: <u>Regular</u>
	ACTIVITY: <u>As tolerated</u>
	MEDICATION ORDERS:
	<u>Indocin 500 mg po TID x 10 days</u>
	<u>Robaxin 1 gm po TID x 10 days</u>
O: PHYSICAL EXAMINATION	
Able to amb to HCU alone.	
Alert and oriented. Skin warm and dry to touch. No lesions or draining wounds present. Good ROM to neck and extremities	
	I.V. ORDERS: <u>NA</u>
	OTHER ORDERS:
A: ADMITTING DIAGNOSIS:	
<u>Admit to infirmary</u>	
ADMITTED BY: <u>W. Vaughn</u> print name	
<u>W. Vaughn</u> signature	

8/23/94

**CORRECTIONAL MEDICAL SYSTEMS
MEDICAL PROGRESS NOTES
INFIRMARY DISCHARGE SUMMARY**

INMATE'S NAME Fountain, Tony
DATE 4-27-98

INMATES NO. 152157
TIME _____

ADMITTED: <u>4-27-98</u>	
DISCHARGED:	CONDITION ON DISCHARGE:
ADMITTING DIAGNOSIS:	
	LAB/TESTS PERFORMED:
DISCHARGE DIAGNOSIS:	
	MEDICATIONS ON DISCHARGE:
BRIEF HISTORY:	
INFIRMARY COURSE:	FOLLOW-UP TREATMENT/PLANS:

8/23/94

DAILY PATIENT ASSESSMENT DEPARTMENT OF CORRECTIONS

Nursing Observations(check only those
which apply)

		Date	4-27-98			4-28-98														
		Shift	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N
C O N D I T I O N	ambulant		✓	✓	✓	✓	✓	✓												
	with assistance																			
	up in chair																			
	bed rest			✓	✓	✓	✓	✓												
	good		✓			✓	✓	✓												
	fair			✓			✓	✓												
	unchanged																			
	depressed																			
	irritable					✓														
	confused																			
	serious						✓													
	uncooperative																			
	side rails		N/A	N/A		N/A														
	up																			
down																				
SLEEP	good			✓	✓	✓	✓	✓												
	restless																			
APPE- TITE	good (80-100%)			✓	✓	✓	✓	✓												
	fair (30-80%)			✓	✓	✓	✓	✓												
	poor (0-30%)																			
	refused																			
D I E T	regular			✓	✓	✓	✓	✓												
	diabetic																			
	liquid																			
	dialysis																			
M E D's	taken as ordered			✓	✓	✓	✓	✓												
	refused																			
	absent from pill call																			
S K I N	rash																			
	edema <i>(swollen)</i>			✓	✓	✓	✓	✓												
	warm & dry		✓	✓	✓	✓	✓	✓												
BATH	self		✓	✓	✓	✓	✓	✓												
	assist																			
ELIMI- NATION	foley																			
	incontinence																			
	urine																			
	feces																			
NAME (LAST, FIRST, MIDDLE)		D.O.B.			AGE			R/S			AIS NUMBER			INST						
Fountain Tony		8/24/63			34			B/M			150157			BCCF						

NURSES' NOTES

F-34

—

[illegible]

Mountain Tom

152157

8-24-63

B/



RELEASE OF RESPONSIBILITY

Inmate's Name: Fountain, Tony
Date of Birth: 8/24/62 Social Security No.: 423 92 6262
Date: 26 OCT 09 Time: 2105 P.M.

This is to certify that I, _____, currently in
(Print Inmate's Name)
custody at the Stator, am refusing to
(Print Facility's Name)

accept the following treatment/recommendations: Absent from sick call
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

(Signature of Inmate)**
P. Dunder CO 1
(Witness)
(Signature of Medical Person)
[Signature]
(Witness)
[Signature]

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



RELEASE OF RESPONSIBILITY

Inmate's Name: Fountain, Tony
Date of Birth: 8/24/63 Social Security No.: 423-92-6262

Date: _____ Time: 2045 P.M.

This is to certify that I, _____, currently in
(Print Inmate's Name)
custody at the _____, am refusing to
(Print Facility's Name)

accept the following treatment/recommendations: No show for sick call
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

(Signature of Inmate)**
Muhamad Noon
(Witness)

(Signature of Medical Person)
[Signature]
(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

HEALTH EVALUATION

YES NO

Weight Change (greater 15 lbs.)
(Compare Weight Below)
Persistent Cough
Chest Pain
Blood in Urine or Stool
Difficult Urination
Other Illnesses (Details)
Smoke, Dip or Chew
ALLERGIES

Weight 181 Temp 97.7 Pulse 60
Eye Exam: 2/20 OD 2/20 OS 2/20 OU

Resp 20 Blood Pressure 140/100 *Self on bed*
If greater than $> 140/60$, repeat in 1 hour.
Refer to M.D. if remains $> 140/90$.

RESULTS

Tuberculin Skin Test (q yr)

Date given 12/13/05 Site 140/100
Read on 12/19/05 Results mm
Survey Completed 12/19/05
Date 12/19/05

Past Positive TB Skin Test
(Chest x-ray if clinical symptoms)
RPR (q 3 yrs)
EKG (1)

Survey Completed 12/20/04 Results WTA
Date 12/20/04 Results WTA
Date 2/8/05 Results WTA

- RPR (q 3 yrs)
- EKG (baseline at 35, over 45 q 3 yrs)
- Cholesterol (at 35 then q 5 yrs)
- Finger Stick Blood Sugar
- * If > than 200

Date 12/25/04 Results —
2/8/05 Results NR
6/25/04 BORDERLINE
 Results S2 NDG 43 FLDL 106
 Results N/A

* If > than 200 repeat Finger Stick BS within 48 hours
Optometry Exam (@ 50 if not already seen)
Mammogram
(females @ 40, q 2 yrs/other M.D. order)

Results S2 HDL 43 LDL 106
Results N/A
Date 12/10 Results —

III. PHYSICAL RESULTS - (RN, Mid-Level, M.D.)

Heart

Lungs

Breast Exam

Rectal (yearly after 45)
with Hemoccult
Pelvic and Papanicolaou

Pelvic and PAP (q 1 yr)

Facility STATION Nurse Signature

M.D. or Mid-Level Signature

INMATE NAME

AIS#

D.O.B.

Date 1/27/06

RACE/SEX

0513-AL (rev 9/05)

Procuttain, Tony

152157

2/26/63

42410

F/272



DEPARTMENT OF CORRECTIONS
NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

Name Alma Fountain Relationship Sister
Street Address 1015 Day St. Rd. Phone Number 262-5975
City Montgomery State Al. Zip Code 36104
Inmate Signature [Signature] Doc# 152157 S.S.# 423-92-6962 Date 12-13-05
Witness Clara Date 12/13/05

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	RACE/SEX	FAC.
<u>Fountain Tony</u>	<u>152157</u>	<u>8-24-62</u>	<u>B/M</u>	<u>SEC</u>



DEPARTMENT OF CORRECTIONS

KITCHEN CLEARANCE
PHYSICAL ASSESMENT

	YES	NO
ANY OPEN SORES OR RASHES ON HANDS, ARMS, FACE & NECK	<u> </u>	<u> ✓ </u>
TB TEST CURRENT	<u> ✓ </u>	<u> </u>
DOES PT. SHOW ANY OBVIOUS SIGNS OF ANY OTHER DISEASE	<u> </u>	<u> ✓ </u>

OTHER: _____

THIS PATIENT HAS BEEN INFORMED OF THE NEED FOR THE FOLLOWING:

PROPER HANDWASHING, NOT TO HANDLE FOOD WHILE SICK, SEEK MEDICAL
EVALUATION WHEN NECESSARY AND TO NOTIFY THE DIETARY SERVICES SHIFT
SUPERVISOR OF ANY ILLNESS.

MEDICAL AUTHORITY: Chauhan DATE: 12/13/05

I attest that the above statement is true to the best of my knowledge.

PATIENT SIGNATURE: [Signature] DATE: 12-13-05

EXPIRATION DATE: _____

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	Race/Sex	FAC.
Fountain Tony	152157	8-24-62	B/M	SCC

Alabama Department of Public Health
TB Division
RSA Tower/201 Monroe Street
Montgomery, ALabama 36130-3017

TB**Skin Test Report**

County Code 06	Target Testing <input type="checkbox"/>	PROJECT 7017	CHR# 152157
Last Name FOUNTAIN			
First Name TONY			
Patient Home Address STATION PO BOX 56			
City EKMORE			
State AL	Zip Code 36025	Home Phone 334-567-1548	
SSN: 423-92-6262		Test Administered By: <input type="radio"/> TB Staff <input type="radio"/> PH Nurse <input checked="" type="radio"/> Other	
Date of Birth: 08-26-1963		Site Test: <input type="radio"/> Health Department <input checked="" type="radio"/> Other	
Race: <input type="radio"/> W <input checked="" type="radio"/> B <input type="radio"/> AI <input type="radio"/> A <input type="radio"/> AN <input type="radio"/> H/PI <input type="radio"/> O		SEX: <input checked="" type="radio"/> M <input type="radio"/> F	
ETHNICITY: Hispanic or Latino: <input type="radio"/> YES <input checked="" type="radio"/> NO		Contact to Case/Suspect: <input type="radio"/> YES <input type="radio"/> NO	
Reason Tested: <input type="radio"/> Health Care Worker <input type="radio"/> Medical Risk <input type="radio"/> Shelter <input type="radio"/> Student <input type="radio"/> Occupational		Risk Categories: <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C	
PPD ONE: Provider#: 00234P Date of Test 12-22-2004 Antigen <input type="radio"/> AP <input checked="" type="radio"/> TU		PPD TWO: Provider#: 00234P Date of Test 12-24-2004 Antigen <input type="radio"/> AP <input checked="" type="radio"/> TU	
Provider#: 00234P Date Read 12-24-2004 Result 0 mm <input type="radio"/> Not Read		Provider#: 00234P Date Read 12-24-2004 Result 0 mm <input type="radio"/> Not Read	

Race codes: W-White; B-Black; AI - American Indian; A-Asian; AN - Alaskan Native; H/PI-Hawaiian/Pacific Islander; O-Other

ADPH-TB - 26/REV-12-2002

4739494381

PRISON
HEALTH
SERVICES
INCORPORATED

YEARLY HEALTH EVALUATION

I. HISTORY - (LPN or RN)

Weight Change (greater 15 lbs.)
(Compare Weight Below)
Persistent Cough
Chest Pain
Blood in Urine or Stool
Difficult Urination
Other Illnesses (Details)
Smoke, Dip or Chew
ALLERGIES

YES NO

COMMENT(S)

☐ ☒
☒ ☐
☐ ☒
☐ ☒
☐ ☒
☒ ☐

Last weight at least 6 months ago

Signed M.D. for MD visit

mom

Weight 161 Temp 97.8 Pulse 54
Eye Exam 2025 OD 2025 OS 2025 OU

Resp 18 Blood Pressure 120/80

If greater than > 140/90, repeat in 1 hour.
Refer to M.D. if remains > 140/90.

II. TESTING - (LPN or RN)

Tuberculin Skin Test (q yr)
Past Positive TB Skin Test
(Chest x-ray if clinical symptoms)
RPR (q 3 yrs)
EKG (baseline at 35, over 45 q 3 yrs)
Cholesterol (at 35 then q 5 yrs)
Tetanus/Diphtheria (q 10 yrs)
(if done today)
Optometry Exam (@ 50 if not already seen)
Mammogram
(females @ 40, q 2 yrs/other M.D. order)

RESULTS

Date given 10/20/04 Site ② P/A
Read on 12/24/04 Results 0 mm
Survey Completed
Date 12/22/04 Results Normal
6-9-04 239
6-25-04 239
Last Given 10-29-99 Due 2009
Site given N/A Dose N/A Lot # N/A
Date N/A Results N/A

III. PHYSICAL RESULTS - (RN, Mid-Level, M.D.)

Heart
Lungs
Breast Exam
Rectal (yearly after 45)
with Hemoccult
Pelvic and PAP (q 1 yr)

51-52 DR/MG
1313 CINE
N/A
Results N/A
Results N/A
Date N/A Results N/A

Facility John Nurse Signature DMCunniff

M.D. or Mid-Level Signature DMCunniff Date 12/22/04

Date 12/22/04

INMATE NAME

AIS#

D.O.B.

RACE/SEX

Fountain, Tony

152157

41
8-20-63

BM



DEPARTMENT OF CORRECTIONS
NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

Name Alma Fountain Relationship Sister
 Street Address 1015 apt-C Day St. Rd.
 City Montgomery State Alabama Phone Number (334) 263-0399
 Inmate Signature [Signature] Zip Code 36108
 Witness [Signature] Doc# 423-92-6862 S.S.# 12-28-01 Date 12/22/04

INMATE NAME (LAST, FIRST, MIDDLE) <u>Fountain, Tony</u>		DOC# <u>152157</u>	DOB <u>4/18-26-63</u>	RACE/SEX <u>BM</u>	FAC. <u>Scion</u>
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PHS-MD-70003 (White - Medical Record, Yellow - Active File, Pink - Control Center)



DEPARTMENT OF CORRECTIONS

KITCHEN CLEARANCE
PHYSICAL ASSESMENTANY OPEN SORES OR RASHES ON
HANDS, ARMS, FACE & NECK

YES

NO

TB TEST CURRENT

DOES PT. SHOW ANY OBVIOUS
SIGNS OF ANY OTHER DISEASEOTHER: _____

THIS PATIENT HAS BEEN INFORMED OF THE NEED FOR THE FOLLOWING:

PROPER HANDWASHING, NOT TO HANDLE FOOD WHILE SICK, SEEK MEDICAL
EVALUATION WHEN NECESSARY AND TO NOTIFY THE DIETARY SERVICES SHIFT
SUPERVISOR OF ANY ILLNESS.MEDICAL AUTHORITY: BMDATE: 12/22/04

I attest that the above statement is true to the best of my knowledge.

PATIENT SIGNATURE: [Signature]DATE: 12-22-04EXPIRATION DATE: 2006

INMATE NAME (LAST, FIRST, MIDDLE)

Fountain, Tom

DOC#

152157

DOB

8-26-63

Race/Sex

BM

FAC.

[Signature]

PHS-MD-70042

(White - Medical File, Yellow - Kitchen Supervisor, Pink - Classification Administrator (Inmate))

Skin Test Report

County Code 06	Target Testing <input checked="" type="checkbox"/>	PROJECT 7017	CHR# 152157
Last Name FOUNTAIN			
First Name TONY			
Patient Home Address STATION PO BOX 56			
City EL MORE	State AL	Zip Code 36025	Home Phone 334-567-1548
SSN: 423-92-6262		Test Administered By: <input type="radio"/> TB Staff <input type="radio"/> PH Nurse <input checked="" type="radio"/> Other	
Date of Birth: 08-26-1963		Site Test: <input type="radio"/> Health Department <input checked="" type="radio"/> Other	
Race: <input checked="" type="radio"/> W <input type="radio"/> B <input type="radio"/> AI <input type="radio"/> A <input type="radio"/> AN <input type="radio"/> HI/PI <input type="radio"/> O		ETHNICITY: Hispanic or Latino: <input type="radio"/> YES <input checked="" type="radio"/> NO	
Reason Tested: <input type="radio"/> Health Care Worker <input type="radio"/> Medical Risk <input type="radio"/> Shelter <input type="radio"/> Student <input type="radio"/> Occupational		Contact to Case/Suspect: <input type="radio"/> YES <input checked="" type="radio"/> NO	
<input type="radio"/> Foreign Born <input type="radio"/> Homeless <input checked="" type="radio"/> Jail/Prison <input type="radio"/> Not at Risk		Risk Categories: <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C	
PPD ONE: Provider#: 0000 Lot#: 002B4P Date of Test: 11-11-2006 Antigen: <input type="radio"/> AP <input checked="" type="radio"/> TU		PPD TWO: Provider#: 0000 Lot#: 000000 Date of Test: 11-11-2006 Antigen: <input type="radio"/> AP <input checked="" type="radio"/> TU	
Provider#: 0000 Date Read: 12-24-2006 Result: 4 mm <input checked="" type="radio"/> Not Read		Provider#: 0000 Date Read: 12-24-2006 Result: 0 mm <input checked="" type="radio"/> Not Read	

Race codes: W-White; B-Black; AI - American Indian; A-Asian; AN - Alaskan Native; HI/PI-Hawaiian/Pacific Islander; O-Other

ADPH-TB - 26/REV-12-2002

Date Given: 10-13-03Site Given: LFADate Read: 10-17-03Lot# 45256261Size in M.M. 0Nurse KRammNurse KRamm

Note: Past Positives and conversions, use Assessment of Tuberculin status for PPD reactors form in addition to completing the bottom of this form.

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Current Weight 175 Previous Weight 165 B/P 120/80

Recent chest pain circle
 Yes or No
 Kitchen clearance assess. done and attached
 Yes or No
 Productive cough
 Yes or No
 Any bleeding
 Yes or No

Emergency contact Lottie B Gray Phone# 334-262-5975
 Address 305 Booker St. Montgomery, AL.
36104

Inmate signature [Signature] Date 10/13/03
 Witness signature [Signature] Date 10/13/03
 DOB 8/26/63 AGE 40 Race B SEX M SSN 423-92-6262
 Inmate Name Fountain Tony AISH 152157

NAPHCARE

Annual Health and TB Screening for Inmates

Facility State

Date Given: 10/25/02 Date Read 10/27/02

Site Given: CFA Size in M.M. 0

Lot# 4256261

Nurse Shackles Nurse Alvin J. Smith

Note: Past Positives and conversions, use Assessment of Tuberculin status for PPD reactors form in addition to completing the bottom of this form.

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Current Weight 165 Previous Weight 170 B/P 120/84

Recent chest pain circle
 Kitchen clearance assess. done and attached
 Productive cough Yes or No
 Any bleeding Yes or No

Emergency contact Lottie Gray Phone# 334-262-5975

Address 305 Booker St

mtg AL 36104

X Inmate signature [Signature] Date 10/25/02

Witness signature [Signature] Date 10/25/02

DOB 8/26/63 AGE 39 Race B SEX M SSN 423 926262

Inmate Name Fountain, Jerry AIS# 152157

NAPHCARE

Annual Health and TB Screening for Inmates

Facility Station

Date Given: 10/6/01 Date Read 10/8/01

Site Given: QFA Size in M.M. Ø

Lot# 45256260

Nurse B. Buckler Nurse N. Woodfin R

Note: Past Positives and conversions, use Assessment of Tuberculin status for PPD reactors form in addition to completing the bottom of this form.

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Current Weight 170 Previous Weight 179 B/P 140/94

Recent chest pain
Kitchen clearance assess. done and attached
Productive cough
Any bleeding

circle
Yes or No
Yes or No in jacket
Yes or No
Yes or No

Emergency contact Letitia B. Gray

Address 305 Booker St,

Phone# 262-5975

Montgomery, Al

36104

Inmate signature

Witness signature

Date 10-6-01

DOB 8/26/63 AGE 38

Race B

SEX M

Date 10-6-01

Inmate Name

Fountain, Tony

SSN

423 926262

AIS#

152157

YES NO COMMENTS

Last Weight at least 6 mo.'s ago:

DJD open

matri

Weight 179 Temp. 96.2 Pulse
Eye Exam: Without Glasses
With Glasses

70 Resp. 20 B.P. 120/80
OD 20/25 OS 20/25 OU 20/25
OD OS OU

RESULTS

Tuberculin Skin Test (q yr.)
 (chest x-ray if clinical symptoms)
 RPR (q 3 yrs.)
 Urine Dip (yearly)
 (Glu., Pro., RBC., WBC.)
 EKG (baseline at 35, over 45 q 3 yrs.)
 Cholesterol (at 35 then q 5 yrs.)
 Tetanus/Diphtheria (q 10 yrs.)
 If Done Today: _____
 Mammogram - (Annually - Females > 49) _____

Date Given 10/8/00 Site USA
Read On 10/16/00 Results 9 mm
Date 11/3/98 Results NR
Results 10/8/00 NR
10/27/98 normal
10/29/99 208
Last Given 10/29/99 Due 2009
Dose _____ Lot # _____
ate Done N/A Results _____

RESULTS

Heart
Lungs
Breast (q 2 yrs. p 30)
Rectal (yearly p 45)
Pelvic and PAP (q 1 yr.)

RRR
Cleen

Date N/A Results _____

Results N/A

Date N/A Hemocult _____

Results _____

Zany

(4 yr.) Date 10/1/00 Results — Hemocult —
Inmate Name Fountain, Tony
DOB 8/26/63 Age 37 Race B Sex M AIS # 152157
Emergency Addressee Lathe, B SSN 423926262
Address 305 Booker St Phone # 3342625779
Facility SCC
Physician Signature — Nurse Signature Monty R. Smith Lpn Date 10/1/00
A. Hartog Date 10/12/00

PPD FOR INMATE

INITIAL SKIN TEST			
Date Given:	10/8/00	Date Read:	10/10/00
Site Given:	LFA	Size:	mm
Lot #:	CO148AA		
Nurse:	N. Ward Jr. R	Nurse:	N. Ward Jr. R

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to TB testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Inmate Signature

Date

Witness Signature

Date

INMATE NAME:	ID#:	RACE:	LOCATION:
Fountain, Tony	152157	Ben	SEC

ES

PERIODIC HEALTH ASSESSMENT

I. HISTORY - (Nurse)

	YES	NO	COMMENTS
Weight Change (>15 lb.) (Compare Weight Below)	—	✓	Last Weight at least 6 mo.'s ago: _____
Persistent Cough	—	✓	_____
Chest Pain	—	✓	_____
Blood In Urine or Stool	—	✓	_____
Difficult Urination	—	✓	_____
Other Illnesses (Details)	—	✓	_____
Smoke, Dip or Chew	✓	—	_____
ALLERGIES	—	✓	DTD Apine
Weight <u>170</u>	—	✓	_____

Temp. 96.8 Pulse 78 Resp. 20 B.P. 120/80
 Eye Exam: Without Glasses OD 29/20 OS 28/20 OU 29/20
 With Glasses OD _____ OS _____ OU _____

II. TESTING - (Nurse)

Tuberculin Skin Test (q yr.)
 (chest x-ray if clinical symptoms)
 RPR (q 3 yrs.)
 Urine Dip (yearly)
 (Glu., Pro., RBC., WBC.)
 EKG (baseline at 35, over 45 q 3 yrs.)
 Cholesterol (at 35 then q 5 yrs.)
 Tetanus/Diphtheria (q 10 yrs.)
 If Done Today:
 Mammogram - (Annually - Females > 49)

Date Given 10/29/99 Site LTA
 Read On 11/1/99 Results 0 mm
 Date 11-3-98 Results NR
 Results 10/29/99 1+protein 2+glucose
10/27/98 normal
10/29/99
 Last Given 1/5/89 Due 0953220 10/29/99
 Site Given Dellad Dose 0.5cc Lot # 0953220
 Date Done N/A Results _____

III. PHYSICAL

Heart
 Lungs
 Breast (q 2 yrs. p 30)
 Rectal (yearly p 45)
 Pelvic and PAP (q 1 yr.)

RESULTS

R.R.R.
clear
 Date N/A Results _____
 Results N/A Hemocult _____
 Date N/A Results _____

Inmate Name Jountain, Tony Race B Sex M AIS # 152157
 DOB 8/24/63 Age 36 SSN 423-92-6960
 Emergency Addressee Bottie P. Henry Phone # 262 5975
 Address 305 Booker St
 Facility SCC
 Physician Signature _____ Nurse Signature AT Smith Date 10/30/99
Henry Date _____

I. HISTORY - (Nurse)

YES NO COMMENTS

Weight Change (>15 lb.) — ✓ Last Weight at least 6 mo.'s. ago: 164 # y2 ago

(Compare Weight Below)

Persistent Cough — ✓

Chest Pain — ✓

Blood In Urine or Stool — ✓

Difficult Urination — ✓

Other Illnesses (Details) ✓ — (States He Has Hx of Asthma)

Smoke, Dip or Chew ✓ ✓

ALLERGIES ✓ — Motrin

Weight 162 Temp. 97.6 Pulse 69 Resp. 18 B.P. 126/87

Eye Exam: Without Glasses OD 20/20 OS 20/20 OU 20/20

With Glasses OD — OS — OU —

II. TESTING - (Nurse)

RESULTS

*Tuberculin Skin Test (q yr.) Date Given 7/14/98 Site 2. Forearm
(chest x-ray if clinical symptoms) Read On 7/17/98 Results 0mm ind

*RPR (q 3 yrs.) Date 10/27/98 Results —

*Urine Dip (yearly) Results 10/27/98
(Glu., Pro., RBC., WBC.) Negative x3 Trace of Glu

*EKG (baseline at 35, over 45 q 3 yrs.) 10/27/98

Cholesterol (at 35 then q 5 yrs.) N/A

Tetanus/Diphtheria (q 10 yrs.) Last Given 1/5/89 Due 1999

If Done Today: Site Given N/A Dose N/A Lot # N/A

Mammogram - (Annually - Females > 49) Date Done N/A Results N/A

III. PHYSICAL

RESULTS

Heart Regular and Even

Lungs Clear Bilat.

Breast (q 2 yrs. p 30) Date N/A Results N/A

Rectal (yearly p 45) Results N/A Hemocult N/A

Pelvic and PAP (q 1 yr.) Date N/A Results N/A

Inmate Name Fountain Tony AIS # 152157

DOB 8/23/63 Age 35 Race Bk Sex M SSN 423-92-6962

Emergency Addressee Jottie B. Gray Phone # 262-597

Address 365 Booker Street Montgomery Ala.

Facility BCCF Nurse Signature C. Faniel p.w. Date 11/9/98

Physician Signature [Signature] Date 11/9/98

CORRECTIONAL MEDICAL SERVICES
INMATE FOOD SERVICE WORKER CLEARANCE

MEDICAL RECORD REVIEW:

Past history of hepatitis:

TB test current:

TB test negative:

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

If history of positive TB test, verified completed treatment:

____ (Date)

PHYSICAL ASSESSMENT:

Open sores or rashes on hands, arms, face and neck:

Has diarrhea:

Has a cough:

Lungs clear to auscultation:

Signs and symptoms of other contagious diseases:

Specify: _____

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

his inmate's Medical Record has been reviewed and he/she has been examined:

☒ He/she IS medically cleared for duty as a food service worker.

☐ He/she IS NOT medically cleared for duty as a food service worker.

W. Randolph UV
Signature

3/20/98
Date

untain, Tony

ID#/DOB:

152157

/ 8/24/63

LOCATION:

BCCF

YES NO COMMENTS

— Last Weight at least 6 mo.'s ago:

ago:

✓

✓

✓

✓

✓

✓

Not Run

Resp. 19 B.P. 128/72
OD 24/15 OS 24/25 OU 20/18
OD _____ OS _____ OU _____
_____ OS _____ OU _____

RESULTS

Date Given 11/23/97 Site Dan
Read On 11/30/97 Results S mm
Date 12-16-96 Results _____
Results 11/28/97

Results 11/28/87
 N/A
 11/11/93
 Last Given 1-5-89 Due _____
 Dose _____ Lot # _____

RESULTS

 Date _____ Results _____
 Results _____
 Results _____
 Date _____ Results _____

Inmate Name Fountain, Tony Date _____ Results _____
 DOB 8-23/63 Age 34 Race B Sex M AIS # 152157
 Emergency Addressee Lottie Gray (mom) SSN 423-92-6962
 Address 305 Backa St Phone # 334 262-5926
 Facility Easterling Nurse Signature [Signature] Date 11/58/97
 Physician Signature _____ Date _____

TUBERCULIN PPD FOR INMATES

INITIAL SKIN TEST	
Date Given: <u>11/28/97</u>	Date Read: <u>11-30-97</u>
Site Given: <u>@ arm</u>	Size: <u>0</u>
Lot #: <u>2442-11</u>	
Nurse: <u>D. Shuler</u>	Nurse: <u>Spashup</u>

I have received a fact sheet on TB and have had the opportunity to have my questions answered. I agreed to TB testing by PPD. I understand the PPD must be read 72 hours after being administered. I have never had a positive reaction to a TB skin test, nor have I ever been treated with TB drugs. I have also been instructed to check with my regular physician or the public health department if I am released prior to the TB test being read.

Inmate Signature

Date

Witness Signature

Date

INMATE NAME: <u>Fountain, Tony</u>	ID#: <u>152157</u>	RACE: <u>B/m</u>	LOCATION: <u>Easterling</u>
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***** MMPI-2 ADULT INTERPRETIVE SYSTEM *****

developed by

Roger L. Greene, Ph.D.
Robert C. Brown, Jr., Ph.D.
and PAR Staff

AMS
Medical
File

-- CLIENT INFORMATION --

Client : Fountain, Tony
Sex : Male
Education :
File Name : 152157
Age : 37
Marital Status :
Date of Birth : 02/22/1963
Prepared for: Kilby Correctional Facility on 09/26/2000.

The interpretive information contained in this report should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. This material should be integrated with all other sources of information in reaching professional decisions about this individual. This report is confidential and intended for use by qualified professionals only. It should not be released to the individual being evaluated.

MMPI-2*

Basic Service Profile Report

ID Number 152157

Male

Age 37

9/15/2000

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[1.6 / 1.0 / 1.0]